STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/09/11 Facility Number: 000369 Provider Number: 155530 AIM Number: 100275190 Surveyor: Richard D. Schade, Life Safety Code Specialist At this Life Safety Code survey, South Shore Health & Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 98 and had a census of 78 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/13/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 6 of more than 100 corridor doors were free from impediments to closing. This deficient practice affects residents, staff and visitors in the resident room smoke compartments on Units 3, 4 and 5. Findings Include: Based on observations made between 2:20 p.m. and 3:10 p.m. on 05/09/11 with the maintenance supervisor, the corridor doors to patient rooms 305, 307, 309, 312, 406 and 507 were blocked open by resident privacy curtains. The	K0018	K018 All residentt privacy curttains were removed ftrom blocking tthe doors enttering tthe main corridors. All residentts have tthe pottenttal tto be aftected by tthis deftcientt practtceAll sttaft will be inserviced on tthe bestt practtce oft ensuring tthatt all curttains are nott blocking tthe residentt doors ftrom closing and/or obsttructtng Addittonally, tthe Mainttenance Directtor will conductt daily rounds ftor ttwo weeks(which shall be deftned as 10 days) and all issues addressed immediattely tthrough correctton, ttraining and/or discipline oft personnel responsible, and nottftying tthe	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	maintenance supervisor acknowledged at the time of the observations the resident room doors were blocked from closing. 3.1-19(b)		administrator. All results of this audit will be submitted to the quality assurance committee for review and processing. Responsible for Completion: Maintenance Director and/or Designee Date of Completion: June 7, 2011	
K0027 SS=F	Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 3 of 3 sets of smoke barrier doors were equipped with the appropriate hardware to allow the door which must close first, to always close first so both doors always close completely. CMS requires smoke barrier doors	K0027	K027 The smoke barrier doors in primary corridors for Units 2, 3, and 4 shall have closing coordinators installed by June 7, 2011. All residents have the potential to be affected by this deficient practice. The maintenance coordinator will be responsible to ensure this	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	equipped with an astragal have a coordinator to ensure the door which must close first always closes first. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 05/09/11 between 2:10 p.m. and 2:50 p.m. with the maintenance supervisor, the smoke barrier doors in the primary corridor to Units 2, 3 and 4, which swing in the same direction lacked a coordinator to allow the door which must close first to always close first. Smoke barrier doors to Units 2 and 3 had only one door which was self closing. The Unit 4 smoke barrier doors close with one door blocking the other from closing. The maintenance supervisor stated at the time of the observation, he was not aware of the problems. 3.1-19(b)		is completted and tthen monittor tto ensure compliance tthrough eftecttve operatton ftor ttwo weeks (which shall be deftned as 10 days) and submitt tthis compliance auditt tto tthe qualitty assurance committee ftor review and processing. Afterwards, tthe Mainttenance Directtor will add tthis tto his weekly rounds tto ensure compliance. Responsible ftor Completton: Mainttenance Directtor and/or Designee Datte oft Completton: June 7, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 6 of more than 12 storage room doors serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice could affect residents, visitors and staff in and near Unit 2 and the kitchen. Findings include: Based on observations with the maintenance supervisor on 05/09/11 between 2:40 p.m. and 2:55 p.m., the two storage room doors on Unit 2 and resident rooms 211 and 212 containing cleaning supplies, equipment and furniture, did not have door closers and did	K0029	K029 All doors identtfted will have auttomattc door closers insttalled by June7, 2011. All residentts have tthe pottenttal tto be aftectted by tthis deftcientt practttce. Each door will be able tto lattch att tthis ttmas well. The diettary manager and mainttenance directtor will monittor tthese closers ftor ttwo weeks (which shall be deftned as 10 days) and submitt tthis compliance auditt tto tthe qualitty assurance committee ftor review and processing Afterwards, tthe Mainttenance Coordinattor will add tto tthe preventtattve mainttenance log tto check tthese areas ittems on a weekly basis. Responsible ftor Completton:	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not automatically close and latch. The door to the kitchen pantry containing boxes, plastics and Styrofoam products and the door to the kitchen clean supply room containing combustibles and cleaning supplies did not automatically close and latch. The maintenance supervisor acknowledged the problem areas at the time of observation. 3.1-19(b)		Mainttenance Directtor and Diettary Manager(and/or designees) Datte oft Completton:June 7, 2011	
K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 3 fire door sets were arranged to automatically close and latch. LSC section 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows 2-1.4.1 requires all closing mechanisms	K0044	K044 The smoke barrier doors in primary corridors ftor Unitts 2, 3, and 4 shall have closing coordinattors insttalled by June 7, 2011. All residentts have tthe pottenttial tto be aftectted by tthis deftcientt practtce.The mainttenance coordinattor will be responsible tto ensure tthis is completted and tthen monittor tto ensure compliance tthrough eftecttve operatton ftor ttwo weeks(which shall be deftned as 10 days) and	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice affects all residents, staff and visitors on and near the facility's Unit 2 and 3. Findings include: Based on observation and interview with the maintenance supervisor on 05/09/11 between 2:15 p.m. and 2:50 p.m., the fire doors to Units 2 and 3 did not close completely and did not latch leaving a gap of approximately three feet. The maintenance supervisor stated at the time of observation, the mechanisms which should close and latch the doors were broken. 3.1-19(b)		submitt tthis compliance auditt tto tthe qualitty assurance committee ftor review and processing. Afterwards, tthe Mainttenance Directtor will add tthis tto his weekly rounds tto ensure compliance. Responsible ftor Completton: Mainttenance Directtor and/or Designee Datte oft Completton: June 7, 2011	
K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to have	K0048	K048 The ftacilitty hereby submitts tthatt a ftull emergency	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1 of 1 written health care occupancy fire safety plans that incorporated items listed in NFPA 101, Section 19.7.2.2., 1. Use of alarms. 2. Transmission of alarms to fire department. 3. response to alarms. 4. Isolation of fire. 5. Evacuation of immediate area. 6. Evacuation of smoke compartment. 7. Preparation of floors and building for evacuation. 8. Extinguishment of fire. This deficient practice affects all residents, staff and visitors in the event of an emergency. Findings include: Based on record review, on 05/09/11 at 2:15 p.m. with the maintenance supervisor, the facility did not have evidence of a complete written health care occupancy fire safety plan or procedure. The Evacuation Policy did not contain procedures for residents being		preparedness disastter plan, as well as conttnuous and ongoing sttaft ttraining relatted tto specifttc dutte,sis in place and available ftor emergency usage. All residentts have tthe pottenttal tto be aftectted by tthis deftcientt practtce As such, all personnel will be rettrained on tthis disastter plan prior tto June 7, 2011. Conttnuous ttraining will be considered qualitty review relatted tto tthis alleged deftcientt practtce Compliance witth ongoing ttraining and educattor, as well as conttnuous updattng oft such disastter plan, will be tthe responsibilitty oft tthe administtrattor Responsible ftor Completton: Administtrattor an/dor Designee Datte oft Completton: June 7, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	safely transferred to a specific meeting area, staff being periodically trained in specific duties to be performed in the event of an evacuation and preparations to evacuate the building. The facility presented no policy or procedure addressing actions to be taken by the facility in the event a power outage should occur since the facility does not have an emergency generator. The maintenance supervisor stated at the time of the record review, he had no other policies or procedures to review unless the facility administrator had them, but he was in a meeting. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 3 of the last 4 quarters. This deficient practice could effect all patients, staff and visitors in the event of an emergency. Findings include: Based on review of the facility's Fire Drill records and interview on 05/09/11 at 1:40 p.m. with the maintenance supervisor, there was no record of a third shift fire drill for the third and fourth quarters of 2010. There was no evidence of fire drills being completed for the first quarter of 2011. The maintenance supervisor	K0050	K050 The Mainttenance Directtor has received a tteachable momentt relatted tto lack oft ftre drills being completted All residentts have tthe pottenttal tto be aftectted by tthis deftcientt practtce. A complette ftre drill schedule has been drafted – in accordance witth tthe sttrattegic varied ttmes ftor shifts – and will be putt in place eftecttve June 7, 2011. Any variance tto tthis schedule will be addressed in tthe qualitty assurance committee meettng. Addittonally, all personnel will be rettrained on ftre preparedness and disastter planning policies prior tto June 7, 2011. Responsible ftor Completton: Mainttenance Directtor and/or Designee	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	acknowledged fire drills were not conducted during the first quarter of 2011 and third shift drills were not completed for the last two quarters of 2010. 3.1-9(b) 3.1-51(c)		Datte oft CompletttonJune 7, 2011	
K0052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on interview and record review, the facility failed to provide evidence of the testing, maintenance and inspection of 1 of 1 fire alarm systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-1.1.1 requires fire alarm systems shall be inspected, tested and maintained. NFPA 72, 7-5.2.2 requires inspection, testing, and maintenance records shall be provided. This deficient practice effects all residents, staff and	K0052	K052 The ftre alarm systtem will be inspectted by June7, 2011. All residentts have tthe pottenttal tto be aftectted by tthis deftcientt practtce. The mainttenance coordinattor has received a tteachable momentt relatted tto tthis deftcientt practtce and now has tthis ittem 'ttcklered' ftor yearly review The inspectton reportt will be submitted tto tthe qualitty assurance committee, nottes only, and notted by administtrattor All inspecttons	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	visitors in the event of an emergency. Findings include: During record review for the fire alarm system inspections with the maintenance supervisor on 05/09/11 at 1:50 p.m., documentation of records of the inspection, maintenance and testing of the fire alarm system could not be found. The maintenance supervisor stated at the time of record review, he had no recollection of an alarm inspection being completed and had no documented evidence to provide. 3.1-19(b)		oft tthis ttype will ttake place att tthe correctt inttervals going ftorward tthrough tthe reminder calendar, as completted by tthe Mainttenance Directtor Responsible ftor Completton: Mainttenance Directtor an/dbr Designee Datte oft Completton: June 7, 2011	
K0054 SS=F	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on record review and interview, the facility failed to	K0054	K054 The smoke dettecttor systtem	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provide written documentation 1 of 1 smoke detection systems had been tested to ensure the detectors were within there listed and marked sensitivity range. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is		will be inspectted by June7, 2011. All residentts have tthe pottenttal tto be aftectted by tthis deftcientt practtce The mainttenance coordinattor has received a tteachable momentt relatted tto tthis deftcientt practtce and now has tthis ittem 'ttcklered' ftor yearly review The inspectton reportt will be submitted tto tthe qualitty assurance committee, nottes only, and notted by administtrattor All inspecttons oft tthis ttype will ttake place att tthe correctt inttervals going ftorward tthrough tthe reminder calendar, as completted by tthe Mainttenance Directtor Responsible ftor Completton: Mainttenance Directtor and/or Designee Datte oft Completton: June 7, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	within its listed and marked sensitivity range it shall be tested using the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires that inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could effect all occupants in the facility including residents, staff, and visitors. Findings include: Based on review of the maintenance records on 05/09/11 at 1:20 p.m. with the maintenance supervisor, there was no written documentation available to show the smoke detectors in the facility had been tested for sensitivity. The maintenance supervisor acknowledged at the time of record review, he had no recollection of a smoke detector sensitivity test being completed and had no documented evidence to provide. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 6 of more than 175 sprinklers which were either corroded or loaded with dirt were replaced. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could effect the staff in and near the kitchen and residents in the Beauty Shop. Findings include: Based on observations during a tour	K0062	K062 The sprinkler heads identtfted will be replaced by June 7, 2011. The ftacilitty will likely do an updatted sprinkler systtem inspectton att tthis same ttme All residentts have tthe pottenttal tto be aftectted by tthis deftcientt practtce The mainttenance coordinattor will monittor sprinkler heads on a montthly basis and any variances tto regulattory compliance will be addressed tto tthe administtrattor ftor immediatte response Any variance will be addressed in tthe qualitty assurance committee meettng ftor review and processing. Responsible ftor Completton: Mainttenance Directtor and/or Designee Datte oft Completton: June 7, 2011	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with the maintenance supervisor on 05/09/11 between 2:25 p.m. and 3:20 p.m., the four automatic sprinklers in the kitchen were loaded with dirt, the sprinkler in the stairwell to the partial basement and in the Beauty Shop were corroded. The maintenance supervisor stated at the time of the observation, he was not aware of the problem. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0066 SS=B	Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on record review, observation and interview; the facility failed to provide written smoking regulations for employees to protect 98 of 98 residents. This deficient practice could effect residents, staff and visitors in and near the smoking areas. Findings include: Based on review of the facility's policy and procedure manual on	K0066	K066 The ftacilitty has drafted a new policy and procedure ftor smoking on tthe premises All residentts have tthe pottenttal tto be aftectted by tthis deftcientt practtce. All employees will be inserviced on tthis policy and procedure during an all-sttaft meettng prior tto June 7, 2011. All residentts currenttly have a policy and procedure in place ftor smoking on tthe premises and tthis policy will be reviewed	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	05/09/11 at 2:20 p.m. with the maintenance supervisor, the facility had no written employee smoking policy or procedure. Based on observations during a tour with the maintenance supervisor on 05/09/11 between 2:25 p.m. and 3:20 p.m., employees were observed smoking outside of the building and the maintenance supervisor stated at the time of observation, smoking was not allowed in the building. The maintenance supervisor acknowledged the lack of a policy at the time of record review. 3.1-19(b)		witth tthe social services directtor and tthen an updatted copy oft such inftormatton will be provided tto residentts and ftamilies. The ftacilitty will monittor compliance oft tthis deftcientt practtce tthrough weekly rounds by tthe mainttenance directtor and quartterly review oft tthis policy by tthe qualitty assurance committee. Responsible ftor Completton: Mainttenance Directtor, Social Services Directtor, and Administtratto (and/or Designees) Datte oft Completton: June 7, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0074 SS=E	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to protect 98 of 98 residents by ensuring all draperies, curtains and valances serving as furnishings were flame resistant in accordance with LSC 10.3.1. This deficient practice could affect residents, staff and visitors in the main corridor near Unit 2. Findings include: Based on observation with the facility maintenance supervisor on 05/09/11 at 2:35 p.m., the facility's	K0074	K074 The drape on Unitt2 has been removed. As all residentts may be aftectted by tthis deftcientt practtce, all drapes on tthis unitt have been checked tto ensure tthey meett regulattory compliance relatted tto ftre rattng. The mainttenance directtor has received a tteachable momentt For qualitty assurance, going ftorward, all ittems oft clotth will be checked prior tto insttallatton (as a secondary eventt, check will happen prior tto purchase) tto ensure ftre rattng is appropriatte Any	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	main corridor near Unit 2 had a drape with no evidence or documentation of fire resistance or being treated with a fire retardant. The maintenance supervisor acknowledged at the time of observation, he did not have evidence of fire resistance or the material being treated with a fire retardant. 3.1-19(b)		variance tto tthis will be correctted immediattely and tthe administtrattor will be nottfted. Addittonally, tthese issues will be submitted tto tthe qualitty assurance committee ftor review and processing Responsible ftor Completton: Maintttenance Directtor and/or Designee Datte oft Completton: June 7, 2011	
K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on record review, observation and interview; the facility failed to ensure 1 of 1 oxygen storage areas was provided with signage indicating the storage of oxygen and smoking was not	K0076	K076 Please see plan oft correctton ftor K066 relatted tto tthe smoking policy. All residentts have tthe pottenttal tto be aftectted by tthis deftcientt practtce. As ftor tthe oxygen	06/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	permitted. This deficient practice could affect staff in and near the oxygen storage room. Findings include: Based on observation with the maintenance supervisor during the tour of the facility at 3:15 p.m. on 05/09/11, the facility's oxygen storage room was not provided with a sign indicating the storage of oxygen and saying smoking was not allowed. Based on review of the facility's policy and procedure manual on 05/09/11 at 2:20 p.m. with the maintenance supervisor, the facility had no written employee smoking policy or procedure. The maintenance supervisor acknowledged at the time of observation, the oxygen storage room had no sign indicating the storage of oxygen in the room and that smoking was not permitted. 3.1-19(b)		room, an identtftying sign indicattng tthe room is an oxygen room has been insttalled Near tthis sign,tthere is a sign indicattng no-smoking. All sttaft will be nottfted aboutt tthis deftcientt practtce during an all sttaft meettng prior tto June7, 2011. The housekeeping directtor will monittor tthis posttng on a daily basis tto ensure tthatt tthe nottftcatton is sttll presentt(ftor10 days). This auditt shall be submitted tto tthe qualitty assurance committee meettng ftor review and processing. Responsible ftor Completton: Housekeeping Directtor and/or Designee Datte oft Completton:June 7, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	05/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE